TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-17-3182-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 29, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding has not received any correspondence with explanation of review or benefits."

Amount in Dispute: $609.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2017	Pharmacy Service – Compound	$609.33	$2.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - This item is reimbursed as a brand-name prescribed drug.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement for the compound in question?

Findings

Memorial is seeking a total reimbursement of $609.33 for a compound dispensed on January 30, 2017. Per Explanation of Bill Review dated March 13, 2017, AIG reimbursed $607.33 for the compound in question on behalf of New Hampshire Insurance Company.

28 Texas Administrative Code §134.503 applies to the services in dispute and states, in pertinent part:

(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
  (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
    (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
    (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
  (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    (A) health care provider; or
    (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compounds in dispute were billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Reimbursement is calculated as follows:

Ingredient	NDC & Type	Price/Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Compounding Fee	NA	NA	NA	$15.00	$15.00	$15.00
Versapro Cream	38779252903 Brand Name	$3.20	40.8 gm	$3.20 x 40.8 x 1.09 = $142.31	$102.00	$102.00
Ethoxy Diglycol	38779190301 Generic	$0.342	4.2 ml	$0.342 x 4.2 x 1.25 = $1.80	$1.44	$1.44
Amitriptyline HCl	38779018904 Generic	$18.24	1.8 gm	$18.24 x 1.8 x 1.25 = $41.04	$31.63	$31.63
Bupivacaine HCl	38779052405 Generic	$45.60	1.2 gm	$45.60 x 1.2 x 1.25 = $68.40	$48.02	$48.02
Gabapentin USP	38779052405 Generic	$59.85	3.6 gm	$59.85 x 3.6 x 1.25 = $269.33	$188.10	$188.10
Amantadine HCl	38779041105 Generic	$24.225	3.0 gm	$24.225 x 3 x 1.25 = $90.84	$38.46	$38.46
Baclofen	38779038809 Generic	$35.63	5.4 gm	$35.63 x 5.4 x 1.25 = $240.50	$184.68	$184.68
					Total	$609.33

The total allowable reimbursement for the compound in dispute is $609.33. The insurance carrier reimbursed $607.33. An additional $2.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $2.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 25, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.